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MANITOBA MEDICAL BULLETIN

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Manitoba Medical Association

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Medical Economics[4]

R. E. Coleman, M.B.

ORIGIN OF MEDICAL CAPITAL

It was decided in the last paper to adopt the pay of the Canadian postal clerk as a unit of measurement for calculating the capital investment represented by a physician practising in Vancouver. Attention was drawn to the fact that the loss of the pay is associated with emotional sacrifices of considerable magnitude. The question was raised as to whether the emotional and financial reward realized by the average physician warranted the average emotional and financial prices paid. In the present paper certain phases of the origin of the financial capital which makes possible the acceptance by the medical student of these financial and emotional losses will be considered.

When the professional economist studies the ultimate origin of capital he reduces his problem to "human factors" which he accepts as denoting the boundaries of his science much as the chemist accepts chemical elements as denoting the boundaries of chemistry. Though the chemist takes advantage of the physicist's extended knowledge of the chemical elements and the economist takes advantage of the extended knowledge of the psychologist concerning the "human factors," yet the two boundaries are more or less definitely accepted. In medical economics, however, the analysis of the "human factors" is the major problem so that, in the following discussion, the bearing of the economist's human factors on capital will be reviewed.

The total capital of a community at any one time has in the main two types of origin. This capital is in part the result of savings and in part the result of tapping new sources of wealth. A man may save a portion of his income or he may originate a new source of wealth. In either case the total capital of the community is increased. There are certain mental and emotional characters associated with the capacity to accomplish either of these results which, though more or less familiar, particularly to physicians, do not commonly lead to the correlations that they seem to warrant. The act of saving may be instinctive or emotional on the one hand, or it may be the result of conscious thought. The storage of units by a squirrel for example is purely instinctive; but when we say that a certain man is a miser we mean that he is activated by emotions that are, in our opinion, not justified by the actual conditions. That is, his act of saving is emotional, not reasonable. On the other hand, when a man saves money for his old age we recognize that the act necessitates the suppression of powerful instincts and emotions. We also have a definite feeling that this last example indicates a superior mental level. Are we right? The answer partly depends upon what type of thinking we consider the more desirable and partly on our reasons for setting whatever standard we do set. The great difficulty in answering a question of this nature is its highly personal significance; personal bias being the strongest and at the same time the most subtle enemy of all scientific reasoning. The result is that under such conditions we feel more secure in our deductions when we can bring to bear independent data which has been sufficiently established in other fields of science to be considered reasonably free from bias. For this reason biological analogies will be drawn which will be found to confirm certain common ideas, and refute certain others concerning the capacity to save, the capacity to tap new sources of wealth and levels of thinking.

In a general way survival is highly desirable to the individual, but it is essential to the group. Therefore that type of mental response would be

Reprinted from the Vancouver Medical Association Bulletin.

the best which best maintains the human race, at the same time with due consideration for the future. Without going into definitions we can correlate thinking, emotions and instincts as follows. A new and strange situation calls for conscious appreciation and conscious motivation. If the experience is repeated sufficiently often everyone knows that a habit is formed. That is, motivation ceases to enter consciousness. With the passage of time, habits imperceptibly merge into emotions as they accumulate dynamic value, as evidenced by the familiar illustration of the real emotional pleasure with which one goes back to old habits, even though the acquiring of the habit was highly irksome at the time of its formation. Every experienced general practitioner is only too familiar with the reality of this sequence, even to the point of the breaking up of homes. Conversely every physician is also familiar with the serious physiological results which may follow alterations in what seem to be minor habits in older persons. When a stereotyped response is carried on through many generations its dynamic value assumes the magnitude of an instinct. In general then, the longer the history of a stereotyped response the greater will be the dynamic force behind it and consequently the greater will be the force necessary to alter or suppress it.

Next let us correlate the effect of time on the intensity of stereotypy, with certain accepted sequences to be found in the independent field of evolution. What would a professional biologist predict concerning the bearing of man's evolutionary history on the habit of saving as evidenced today? Speaking in evolutionary periods, saving, in the sense that we are using the word, is of such recent origin that one might almost call it the present. Until agricultural methods had developed to the point that harvests could be stored and held over long enough to offset a crop failure, nature set a premium on those individuals who could act most efficiently in the present. How recent this is, for the progressive and dominant Western nations is indicated by the history of English farming. Even as late as the fifteenth century practically all of rural England was commonly on the verge of starvation. The general nature of the crops was such that even during ordinary winters only the strongest cattle were kept over, the rest having to be slaughtered, and even these selected animals were but skin and bones by the spring. Therefore the accepted sequence of biological evolution would lead us to predict a selective process resulting in a high numerical predominance today in the human race of those individuals whose stereotypy would attain maximum efficiency in dealing with the present, as contrasted with those individuals whose present actions would be largely controlled by possible future results. This would lead us to anticipate that the present generation would tend to react most efficiently in the present. Also since, as we have already noted, instincts during evolutionary time accumulate dynamic force, the inclination to consider only the present would tend to have the dynamic value of an instinct. Therefore any alteration calling for the suppression of this primary impulse for the present satisfaction in favour of future possible benefit would demand at least an equivalent amount of emotional energy from an opposing source. That is, the inclination to save would be opposed by an instinct to consider only the present.

When we look for emotional forces which could control or suppress these habits, emotions and instincts arising from the unconscious and which call for stereotyped responses based upon innumerable past experiences, chiefly calling for consideration of the present, we must seek for them in the conscious rather than the unconscious phases of the mind. It is obvious that to meet such a situation the individual must be able to appraise consciously the present and future, with sufficient emotional force to offset the dynamic effect of the unconscious or automatic tendencies to ignore the future. Speaking generally

we can divide individuals into two groups. The one group tends to act impulsively in a stereotyped manner to all stimuli, the nature of the response varying little with variations in the setting. The other group tends to react as a result of conscious thought, their primary stereotypy being kept in check. Since the type of response is determined by the play of unconscious and conscious forces we would anticipate that those individuals who consciously visualized the widest intellectual terrain would be most effective in controlling the primary stereotyped responses. That is, there would be a marked tendency for mental superiors (using the term in its obvious sense) through their broader mental vision to outstrip the inferiors in any field that required control or suppression of instincts or emotions in favour of new situations because the larger number of conscious opposing stimuli would be more likely to assume the magnitude necessary to suppress the instinct.

Thus we find that a consideration of the mechanism by which habits, emotions and instincts are developed, along with certain accepted facts from the independent field of biology leads us to anticipate that the mental reaction which leads to saving a part of present assets for possible future needs would tend to be found chiefly in individuals with superior mental capacity. That is, one of the economist's "human factors" responsible for setting up that portion of the community's capital which owes its origin to savings in the intellectual level of the community. Further, since the saving effected by the mental inferiors is purely imitative, in the last analysis practically all of the savings of the community would tend to owe their ultimate origin to the mental superiors. In a general way these ideas are common knowledge, but the above analysis seems to warrant a much wider application than the casual observer feels free to admit.

Now, let us consider the ultimate origin of that portion of the community's capital which owes its origin to tapping new sources of wealth. Such increases are of the general nature of discoveries, inventions, etc.

The man who discovers a coal mine in a sense increases the community's capital, but on second thought it is apparent that the increase of the community's wealth is more directly dependent upon the many inventions that make it possible to mine, transport and utilize the coal, than on the coal in the mine. Communities without any coal are able to secure it as a result of such inventions. This brings up the whole question of the biological drift of the capacity to invent or make discoveries. Throughout the entire animal and vegetable world there are two tendencies that are continually at war. On the one hand there is a tendency to stereotyped repetitions and on the other hand there is a tendency to alterations. The science of heredity itself is chiefly a mathematical study of the balance between these forces. When we reach the mental level of the mammals we find that the young tend to experiment more than do the adults. There are two different processes which combine to effect this change in the individual. They are both familiar, especially to the physician. One in the decrease of surplus energy with increasing age, and the other is the suppression of curiosity, incident to experience. The practicing physician is only too familiar with the loss of interest and curiosity coincident with loss of physical strength in disease, but the bearing of this factor on inventions will be left to a future paper. For the present we will deal only with the bearing that biological selection and the particular experiences of the individual have on the faculty of curiosity. The survival of a biological group is in part the sum of the play between stereotyped repetitions and of individual experiments resulting from curiosity. One of the chief causes of man's dominance has been his curiosity, so that we would anticipate that selection would have maintained a high value for this faculty in the human group, more especially in the advanced races which owe much

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of their domination to the curiosity, a direct contrast with the biological development of the tendency to save. On the other hand every one is familiar with the fact that most curiosity is non-productive. Indeed it is actually so dangerous that the excessively curious child is notoriously a great worry to its mother. The technic by means of which mothers curb this faculty in the nursery is the bogie, which principle is carried over into adult life under the general caption of taboo. The principle of bogies and taboos is that they act on the mind of the individual in the absence of supervision by others. The actual dangers of experiments, to the individual and the group, are such that some mechanism was almost essential to prevent the death of the individual on the one hand and to prevent the extermination of the group on the other hand. One of the consequences of the taboo is to create in the mind of the individual an actual fear of the curiosity impulse itself. The very temptation to experiment uncovers its own antagonistic fear, so that the individual either completely curbs the impulse to experiment or manifests the usual symptoms of an emotional conflict, such as nervous tension. One of the most potent examples of taboo is the English expression, "It is not done." Also, no doubt many good experimenters were completely suppressed in England by the oft repeated remark of a father, "What was good enough for your father and your grandfather will be good enough for you." The history of the resistance to improvements in English farming is replete with illustrations of the efficiency of this as a taboo.

Many of the familiar results of this conflict between the native curiosity instinct and its acquired antagonistic fear could be anticipated. For example the individual with few impulses would seldom come in conflict with the taboo and so would experience relatively little difficulty in accepting the restraint. Also the individual whose impulses carried minimal dynamic values, even though the impulses themselves were frequent, would similarly experience relatively little difficulty in accepting the restraint. On the other hand those individuals whose curiosity impulses carried maximum dynamic values would have to develop maximum fear to effect suppression. If such individuals were unfortunate enough to have frequent or continuous impulses they would be subject to frequent or continuous fears. The psychiatrist also knows that for the most part the individual would simply experience the fear without any conscious appreciation of its cause. The manifestations of this fear would be a feeling of inferiority, insecurity, irritability, pugnacity, etc.; the usual signs of emotional conflict. It would be further anticipated that in some individuals the fear of the taboo would be insufficient to completely suppress the dynamic force of the curiosity impulse so that the individual might either reduce the fear by experimenting in secret or might set out to fight the origin of the fear which is the social structure about him; *i.e.*, the individual becomes antisocial. Whether or not then a given individual would succeed in completely suppressing the curiosity impulse would depend upon the strength and frequency of the impulses and upon whether or not the impulse was rewarded. This gives us the answer to our question as the ultimate origin of that portion of the community's capital that is the product of discoveries and inventions. It is apparent that new ideas will present themselves most often to those individuals whom we recognize as having superior intelligence. It is also apparent that the broader the mental horizon the more frequently the new idea will be found to fit in with the actual facts and so receive reward. There seems therefore little reason to doubt that the tapping of new wealth by the community owes its ultimate origin in the main to the mental superiors. It is also clear, unfortunately, that in many individuals the price of their discoveries will be excessive to the point of making them more or less anti-social, an altogether too common occurrence.

SUMMARY

Though it is commonly appreciated that individuals with mental capacities above the average tend to save more than do those of lesser mental capacity and similarly those with superior mentality tend to make more profitable discoveries, the bearing that this has on the total capital controlled by the community is not commonly appreciated among the members of the medical profession. Well established facts of common scientific knowledge are presented which indicate that for practical purposes the capital of the community owes its origin to the mental superiors. In a later paper it is proposed to show the bearing that the origin of the capital represented by the medical graduate has on medical economics.

Manitoba Medical History

By ROSS MITCHELL

HOW DANIEL HARMON CAME TO MANITOBA

Daniel Williams Harmon was a Vermont lad who entered the service of the North West Company in 1800 and was sent west. For the next nineteen years he did not come east to Fort William, not till May, 1819, did he turn his back on the west and return to his native state where in the next year his journals were edited and published. The following extract describes his entry into the west:

Tuesday, July 29th (1800). This day we came across the Woody Lake (Lake of the Woods) which is full of islands. It is about thirty-six miles in length; and the soil about it is much like that, along the Rainy River. We are now in Winipick River, and have passed a rapid where the last year, three men were drowned. One of our men fired at a black bear, but did not kill him.

Wednesday, 30. Passed a number of miry Portages, and a place where, three years since, the Natives, who are Chippeways, fired upon our people, but without killing any of them. One of the Indians was taken, with the intention of carrying him to the nearest Fort, and there punishing him as he deserved. After proceeding a considerable distance, however, and when near a rapid, he jumped out of the canoe, intending, as was supposed, to swim to the opposite shore, and thus escape. But the current was too strong; and he went down the rapid, and was probably drowned.

Thursday, 31. Mouth of the River Winipick. Here the North West Company, and the Hudson Bay Company, have each a fort. Here the above named river discharges its waters into Lake Winipick. The River Winipick, through the greater part of its course, is a succession of small lakes; and in several places there are falls, of a considerable height. The country around it is broken; and occasionall, majestick and frightfall waterfalls are to be seen, particularly where the White River joins this, about thirty miles above where we now are. A few miles above this, there is a small lake, called Lac de Bonne, from which the Hudson Bay people leave our rout, and proceed towards the Albany Factory. The soil is good; and among the fruit, I observe the red plum. The grape, also, grows well in this vicinity. In the neighbouring woods, a few moose and deer are found; and the Lake and River are well supplied with fish. Our people are employed in drying the goods some of which were wet, in coming down the rapids, yesterday.

Saturday, August 2. When I left the Grand Portage, it was expected that I should go up the Sisiscatchwin river, to spend the winter. That river falls into the north western end of Lake Winipick. But, since our arrival here, we have received intelligence from the Swan River Department, which

country lies between Lake Winipick and the Red and Assiniboin Rivers, that, in the opinion of Mr. McLeod, who superintends the concerns of that region, it is necessary to make another establishment there. It is therefore determined that I shall go and take charge of it; and I shall accordingly remain here a few days, to wait for the arrival of the brigade, destined to the Swan River department. The after part of the day, I spent in shooting pigeons, which I found to be numerous, as at this season, red raspberries, and other kinds of fruit, are ripe, and exist here in abundance.

Sunday, 3. In walking in the adjacent country, I saw the bushes and brambles loaded with ripe fruit. While partaking of it, I was led to reflect on the beneficence of the great Author of nature, who scatters his favours with an unsparing hand, and spreads a table here in the wilderness, for the refreshment of his creatures.

This is the first day which I have ever spent, since my infancy, without eating either bread or biscuit. As a substitute for bread, we now make use of what the Natives call pimican, which consists of lean meat, dried and pounded fine, and then mixed with melted fat. This compound is put into bags, made of the skins of the buffaloe, &c. and when cold, it becomes a solid body. If kept in a dry place, it will continue good for years. But, if exposed to moisture, it will soon become musty, and unfit for use. Pimican is a very palatable, nourishing and healthy food; and on it, our Voyagers subsist, while travelling in this country. Sometimes we add to the above named ingredients, sugar or dried berries, which we procure from the Natives; and the taste of it is thus very much improved.

Current Medical Events

MILEAGES—TAKING PATIENT TO DOCTOR

At the last convention of the Saskatchewan Association of Rural Municipalities, we heard a lot about the charges which doctors make for calling on patients. There were a lot of complaints about the alleged high charges which doctors make for mileage. The remark was made that a doctor should be able to travel for the same mileage which a councillor gets, *namely*, about ten cents per mile. The persons who made this remark forgot that the councillor knows a long time before when he will have to go to a council meeting and he can make the trip in the daytime and he has plenty of time in which to prepare for the trip if it is in the winter time and the roads are full of snow and next to impassable. On the other hand, the doctor does not know when he will be called out. He must be prepared to travel by car and if the roads are not passable for a car, he must have a horse-drawn vehicle in readiness to go, day or night. He has no time in which to prepare for a trip. He is expected to go without any delay and not to ask questions about the pay for the trip.

Now, where we live, everybody has got the habit of taking the sick and injured to the doctor. We think this is better than bringing the doctor to the sick or injured person. On the average, we are about sixty miles from Medicine Hat and about forty miles from Maple Creek. We have the idea that the best thing we can do for a sick or injured person is to get him or her into a hospital and under a doctor's care as soon as possible. Better attention can be given in a hospital than in any home and the doctor can do much more and work far more efficiently in a hospital where he has things

handy than he can out in a field or in the average home. When your car breaks down, you have it towed to a garage; you do not as a rule try to bring the mechanic and the garage out to the mud hole where your car is broken down.

* * * *

BORDER MEDICAL SOCIETY MEETING

The May meeting of the Border Medical Society was held on Thursday, May 26th, 1932, at San Haven Sanatorium, Dunseith, North Dakota.

The programme was as follows:

Reading of minutes of previous meeting by the Secretary.

Address by the President.

"Presentation of Cases and X-Rays" by members of the medical staff, San Haven Sanatorium.

"Tuberculosis Today" by Dr. D. A. Stewart, Superintendent, Ninette Sanatorium.

"Tuberculosis" by Dr. French, Dean of North Dakota Medical College, Grand Forks, North Dakota.

Discussion of Papers by Dr. Cyril Glaspel, Grafton, North Dakota.

* * * *

CANADIAN AND AMERICAN PHYSICIANS' FRENCH SPA TOUR
Third Annual Tour, 1932

Leave New York on July 15th, 1932, on the S. S. "Lafayette", landing at Havre, early Saturday morning, July 23rd. At Havre there will be no customs formalities for members of the group.

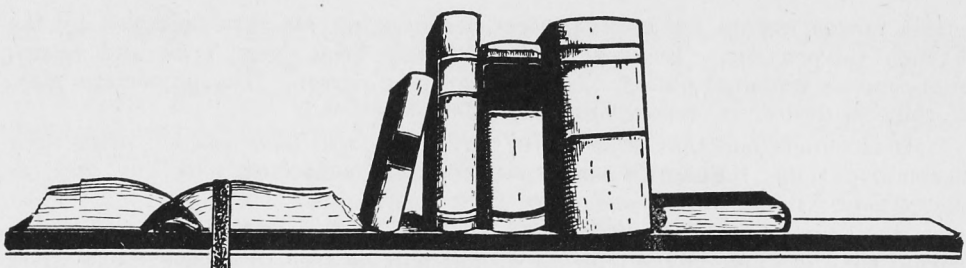
A special train will carry the members of the group to Paris and the entire party will be transported to the Hôtel Continental in Paris.

Sunday, July 24th and Monday, July 25th, will be spent in Paris. Leaving Paris on Tuesday, July 26th, the party will proceed by special train with wagon restaurant car and baggage car for Strasbourg. A special train will be at the disposal of the group throughout the entire trip. The travelling will be done entirely by daylight and meals will be served en route.

Between July 26th and August 20th the following Cities, Spas and Watering Resorts will be visited: Strasbourg, Contrexeville, Vittel, Evian-les-Bains, Aix-les-Bains, Avignon, Nice, Grand Corniche, La Turbie, Menton, Monte Carlo, Monaco, Cap D'Ail, Beaulieu, Villefranche, Cagnes, Antibes, Cap D'Antibes, Juan-les-Pins, Cannes, Marseille, Carcassonne, Luchon, Superbagneres, Biarritz, St. Jean de Luz, Dax, Hossegos, Vichy, Paris. On Saturday evening, August 20th, the party will arrive in Paris and remain there until Wednesday, August 24th, when departure will be made from St. Lazare Station for Havre, returning on the S. S. "Paris", arriving in New York on Tuesday, August 30th.

Throughout the trip, first class accommodations will be provided, with the entire party always at the same hotel. In the Cities where Spas are visited, an official reception, banquets, a lecture by a professor of medicine, evening at the theatre, automobile trips in the neighborhood, etc., will be held.

The accommodations, meals, automobiles, luggage and other details connected with the trip, will be arranged and carried out by the representatives of the French Government. Each member participating in the trip is required to pay 935 dollars. This is the total expense for the trip, so far as the member is concerned. All steamship transportation, hotel expenses,



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meals, special trains, lectures, theatres, motor trips, etc., are defrayed by the French Government. In short the entire trip from New York and return represents a personal outlay of 935 dollars per person. The physicians may, if they so desire, be accompanied by their families.

It is understood that none of the physicians will have to look after their accommodations, luggage, or any other detail connected with the trip, as everything will be taken care of by their host.

Members of the delegation wishing to remain in France for a longer period than the official trip can do so and will be free to choose the steamer most convenient to them, but must be one of the French Line.

There are plenty of free days and half days for golf and side trips. At places like Vittel, there are golf, tennis and horseback riding.

As a practical detail, the amount of baggage should be confined to the least possible convenient limit. Dinner coats are essential but tail coats not required.

For information or registration please communicate with Dr. Léon Gérin-Lajoie, 1414, Drummond Street, Montreal, Que.

* * * *

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May refer for further information to Dr. F. M. Turner, Toronto General Trusts Building, Smith and Portage, Winnipeg.

* * * *

WINNIPEG MEDICAL SOCIETY

At the annual meeting of the Winnipeg Medical Society, held May 20th, 1932, the following officers were elected for the 1932-33 season:

President	Dr. F. J. Hart
Vice-President	Dr. W. W. Musgrove
Secretary	Dr. O. C. Trainor
Treasurer	Dr. O. J. Day
Trustee (3 years)	Dr. A. P. MacKinnon

* * * *

CARDSTON'S NEW SCHEME

Cardston community is experimenting with something new in the way of medical treatment. It is a co-operative scheme between the two medical practitioners of the town and families of the community, whereby a charge of $25 per annum per family will create a community fund from which the doctors will be paid. Over $3,600 has already been collected, and further families are signing up. The scheme proposes regular medical examinations in an effort to "keep the community well."

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
BY-ELECTION

A recent By-Election for representative to the Council of the College of Physicians and Surgeons of Manitoba from the District of Brandon resulted in the election of Dr. H. O. McDiarmid.

* * * *

RE. ANNUAL MEETING

Preliminary arrangements are now under way for the Annual Meeting of the Association to be held September 8th, 9th and 10th, in Winnipeg. We are fortunate indeed to be able to report that the following will comprise the list of visiting speakers at this meeting:

DR. W. E. GALLIE,
Professor of Surgery, University of Toronto.

DR. F. R. MILLER,
Professor of Physiology, Western University Medical School, London.

DR. GEO. C. HALE,
Professor of Medicine, Western University Medical School, London.

DR. W. B. HENDRY,
Professor of Obstetrics and Gynæcology, University of Toronto.

DR. W. A. FANSLER,
Assistant Professor of Surgery, University of Minnesota.
Consulting Proctologist, Glen Lake Sanatorium, Minneapolis, Minn.

We wish very much to supplement these papers by others from our own local men. We would therefore request that any physician who has a paper which might be of interest to the profession please notify the Secretary at the earliest possible date.

* * * *

A prize of one hundred dollars has been awarded by the Canadian Tuberculosis Association to Dr. John Cruise of the staff of the Manitoba Sanatorium, Ninette, for a study of Erythema Nodosum in Undergraduate Nurses and its Relationship to Tuberculosis.

The wisest psychology will never replace quinine and mercury in the cure of certain diseases, nor can it obviate the necessity of operative procedure for a perforated appendix.—*C. F. Martin.*

NEWS ITEMS

— *from* —

Department of Health and Public Welfare

NEW APPOINTMENTS

Dr. Noel R. Rawson, who has just completed his academic training, leading to the Degree of D.P.H., at the School of Hygiene, University of Toronto, has joined the staff of the Department of Health and Public Welfare as Acting Epidemiologist, to obtain the four month field work required before the D.P.H. is granted.

We are very pleased indeed to obtain the services of Doctor Rawson in this branch of our service, and feel that he will be of real assistance to the profession in Rural Manitoba.

* * * * *

REPORTS

The following is a copy of the report of the Legislative Committee, appointed to study the various phases of "Public Health," which was presented to, and adopted by, the Legislature of Manitoba at their recent Session:

TO THE HONOURABLE THE LEGISLATIVE ASSEMBLY
OF MANITOBA:

Your Legislative Committee on the Resolution, introduced by Hon. Member for Birtle, and agreed to on March 31st, 1931:

"WHEREAS at the last session of this Legislature the following Resolution was unanimously passed, namely:

"WHEREAS, owing to fear of inability to pay, many persons do not avail themselves of medical services and hospital facilities;

"AND WHEREAS the public health is a matter of paramount importance, not only to the individual, but also to the State;

"AND WHEREAS it is in the public interest to extend the practice of preventive medicine and to make more readily available medical services and hospital facilities to a greater number of persons;

"BE IT RESOLVED, That the Minister of Health and Public Welfare be requested to consider the making of a comprehensive departmental enquiry and report to this House regarding the following matters, namely:

1. Preventive Medicine;
2. Municipalization of medical and hospital services;
3. Logical health areas;
4. Health insurance and other practical methods for the more equal distribution of the cost of illness;
5. Public medical services;
6. Practical methods for making special required methods of diagnosis and treatment in certain diseases more readily available.

Such departmental report to form the basis for investigation and consideration by a Special Select Committee of this House, to be later appointed for the purpose of co-operation with the Minister of Health and Public Welfare in the formulation of a comprehensive public health scheme for the Province of Manitoba, with a view to providing more efficient and economical public health services."

THEREFORE BE IT FURTHER RESOLVED, That a Special Select Committee be appointed to inquire into, study and consider the Report of the Department of Health and Public Welfare, on the matters mentioned in the said Resolution. And that such Committee have power to sit during the present Session and in the recess after adjournment or prorogation, and in due course to report to this House the recommendation of said Committee. Such Committee, consisting of the following persons, namely:

Honourable Mr. Montgomery,	Mr. Farmer,
Mrs. Rogers,	Mr. McGavin,
Mr. Beresford,	Mr. Morton,
Mr. Campbell,	Mr. Poole,
Mr. Schultz,	Mr. Rutledge,

and the mover of this motion.

Begs leave to present the following as its complete report:—

During the year the Committee have held meetings and representatives of many organizations have appeared, including:

Mr. D. L. Mellish	Union of Manitoba Municipalities
Dr. D. A. Stewart	Sanatoria Board of Manitoba
Dr. W. G. Campbell	College of Physicians and Surgeons
Dr. A. T. Mathers	Provincial Psychiatrist
Mrs. Gee-Curtis	United Farm Women of Manitoba
Dr. A. E. Proctor	Manitoba Dental Association
Mrs. Margaret Speechley	Women's Institutes of Manitoba
Mrs. Jas. Aiken Eliza J. Williams	Women's Labour League
Mr. Hugh J. Munro	Winnipeg Chiropractor's Association
Mr. Earnest L. Buchanan	Christian Science Union
Dr. Ross Mitchell	Manitoba Medical Association
Mr. Metcalfe Dr. Geo. Stephens	Manitoba Hospital Association
Mrs. Stella G. Kerr	Manitoba Graduate Nurses Ass'n.
Dr. E. J. Boardman	Private Representative
Dr. Harvey Smith	" "
Mrs. Knight	" "
Mr. Wm. Ivens, M.L.A.	" "

In addition to appearing before the Committee the above persons also submitted written statements, which, together with the minutes of the meetings are on file.

To obtain the views of the Municipalities throughout the Province a questionnaire was sent out and various opinions obtained. From the replies received it is evident that there is a lack of full information regarding public health policies.

We express our appreciation of the consideration of those to whom we have applied for information, and in particular to the officials of the Department of Health and Public Welfare. The representatives who attended before the Committee have all shown a desire to be of assistance. The spirit of co-operation and the desire of all persons to assist have been a real inspiration to the Committee.

It early became apparent to your Committee that the question of public health policy and medical supply was of necessity closely connected with the general economic situation. It is apparent that any reforms in our present health services must take into consideration the fact that individuals, municipalities, and the Province itself, are adversely affected by the present depres-

sion, and this situation will make changes in our health policies inevitable. The financial aspect is particularly acute in the rural areas where free consultant clinics are not available and where the local medical and hospital services are not being fully utilized for lack of funds.

A general survey of our health problems makes it clear that the distribution of population forms three distinct areas with varying conditions. These areas may roughly be indicated as follows:

1. Greater Winnipeg in which we find readily available medical and hospital attention with one doctor for every 900 of population;
2. The rest of the organized part of the Province in which a good type of medical and hospital service is available, providing the individual has sufficient funds to pay for same. In this area there is one doctor for every 2,000 of population.
3. The disorganized and unorganized territory in which medical and hospital services are not readily available, and where poor roads and great distances handicap the few resident doctors. In this area the majority of the residents would be unable to pay for the services if they were available. In this area there is one doctor for every 5,000 of population.

To formulate a health scheme in every detail applicable to such varying conditions and localities would require more investigation than your Committee could undertake in the time at its disposal. The evidence submitted to us, however, while it varies on many points, agrees on this one general principle;—

THAT THE COST OF ILLNESS SHOULD BE PROVIDED FOR IN ADVANCE OF ILLNESS, AND THE COST SHOULD BE SO DISTRIBUTED THAT IT BEARS EQUITABLY UPON ALL.

This principle, we think, should be accepted and borne in mind when considering the recommendations hereinafter made, particularly with reference to the formulation of any definite scheme.

Your Committee is of the opinion that in Greater Winnipeg and the larger towns of Manitoba, some form of Health Insurance appears to be the best solution, while in many rural areas a scheme of municipalization appears feasible. In regard to municipalization, particularly, we believe that there is a lack of understanding, and some of the opposition to the idea may be attributed to a failure to appreciate its operation. The success of any public health policy will depend on the co-operation of an undersstanding public.

Your Committee has, in the appended material, made certain general recommendations. Pending action being taken in regard to these, we submit information regarding the matters specifically referred to us for consideration, together with some recommendations in regard thereto.

GENERAL FINDINGS

(a) PREVENTIVE MEDICINE: It may be stated as axiomatic that the first duty of any health agency, medical or otherwise, is to prevent illness. Illness of any kind is an economic waste, and the ideal of health service is prevention. Preventive medicine can only be successful when there exists between the state and the citizen, between the doctor and the patient, the fullest measure of co-operation. Under a system of private practice preventive medicine restricts and decreases the opportunities of those engaged in the healing art; carried to its logical conclusion it would make their services largely unnecessary. It is to the credit of the medical profession that despite this fact the physicians of this Province have co-operated unselfishly with those agencies that endeavor to control and prevent disease. Nevertheless, it

can readily be seen that under a system of state medicine or a system of municipalization the medical practitioner would lighten and best discharge his duties by preventing disease as far as possible. Admittedly the most effective kind of preventive medicine is secured by specially trained medical practitioners and other personnel devoting all their time and energies to the subject, as is exemplified in all full-time municipal health service, and demonstrated by the health unit plan; but, failing this, it is reasonable to suppose that municipalization will tend to make preventive medicine a more logical and effective service than it would be under a system of private practice.

It has also been proven that under the present system of medical supply a great deal of preventive medicine is wasted in as much as many people are not educated to the value of the advice given or cannot take advantage of it for lack of funds. Clinical examinations show a large number of defects discovered and reported; but, particularly in rural areas, little action is taken to remedy these defects. In many cases it is evident that there is a lack of means to secure the necessary curative treatment. Under municipalization, much curative work can be undertaken without a direct liability to the patient.

There is a feeling that, in regard to preventive medicine, the entire cost should not be a provincial matter, but should be shared with the Federal authorities. To a limited extent, in regard to immigrants and certain diseases, this responsibility has been recognized by the Dominion. We believe this principle might be extended and the share of the Dominion increased, although the primary responsibility must always be a provincial and municipal one.

SUMMARY OF FINDINGS

1. PREVENTIVE MEDICINE possibly may be best carried on in conjunction with some measure of municipalization or state medicine;
2. PREVENTIVE MEDICINE, to be effective, requires the co-operation of a health-conscious public;
3. PREVENTIVE MEDICINE is primarily a municipal and provincial responsibility, but it is reasonable to expect a measure of Federal assistance;
4. PREVENTIVE AND CURATIVE MEDICINE in many cases, for reasons of economy and efficiency, may be combined in many rural areas.

(b) (i) MUNICIPALIZATION OF MEDICAL SERVICES: A considerable portion of the time of the Committee was devoted to this question. It is generally referred to as "The Municipal Doctor Plan" and in brief it suggests that private practitioners supported by the Collection of fees be replaced by public practitioners engaged on salary, paid by the municipality, or other unit organization.

No consideration of the plan should overlook the fact that in the past the medical profession has given its services to the public generously. The profession has rendered this Province a magnificent contribution in the care of the sick, in the prevention of disease, and in assisting forward movements of public health. In the rural areas medical men have given much of their services free of charge; in the cities they have provided free clinics.

A recognition of these facts makes it obligatory upon this Committee to recommend that any change in health services should take into consideration not only the public interests to be served, but also that fair treatment be accorded the medical profession which is so vitally affected.

Municipalization appears to be feasible in many rural areas. It cannot as successfully, or conveniently, be applied to urban conditions, and any deficiency of health services in cities and towns might be remedied in other ways. In rural Manitoba it may be stated that, where a private practitioner provides medical services for the people of his district without demanding or securing payment, except when times are good, he is really carrying the financial responsibility. In the older settled parts of the Province this is true at the present time and as long as this situation continues, there will be little demand for municipalization in such areas because, in effect, municipalization would place the responsibility, now carried by the resident physician, on the municipality. It would appear to us that this is a situation that will continue only as long as the resources of the individual practitioners are equal to the financial strain. Eventually another method will become necessary and municipalization appears the most satisfactory solution.

While municipalization appears feasible to your Committee, we suggest that there is urgent need for educating the public, generally, as to the importance of health services and securing in advance the co-operation that is so essential to the successful working of a new system.

It is not contended that the system is without fault. Reports from the Province of Saskatchewan, where it is in operation in thirty-six districts, and from this Province, where it is in operation in five districts, indicate it is giving a considerable measure of satisfaction. In Manitoba, Municipal Officials and the general public are not conversant with the details of the plan. We believe they should give the entire question their best consideration and earnest study. The most important feature to be kept in mind in working out any scheme of municipalization is the education of the public.

SUMMARY OF FINDINGS

(1) THAT municipalization appears to be a feasible method of supplying medical services in some rural areas, and provides for the cost of illness in advance.

(2) THAT the municipality is not in itself a suitable geographical unit for such a plan;

(3) THAT the system at present is developing haphazardly and without any centralized control;

(4) THAT to insure a successful working of the scheme the co-operation and support of the public is necessary and therefore to insure that support, and a measure of permanency, a vote should be required to introduce the system into any area;

(5) THAT the terms of the contract as between doctor and municipality is a matter for consideration by the Union of Manitoba Municipalities and the Manitoba Medical Association;

(6) THAT municipalization offers the best method of treating the indigent sick and preventing their hospital bills becoming a burden on the Municipality;

(7) THAT it appears to be the most economical way of supplying medical services and equally distributing the burden of cost in many rural areas;

(8) THAT the scheme, being dependent for its financial support on the taxation of real property, is handicapped and retarded;

(9) THAT municipalization of medical services tends to correlate preventive and curative medicine to a greater extent than at present;

(10) THAT municipalization restricts the right of the patient to choose his own form of medical care.

(b) (ii) MUNICIPALIZATION OF HOSPITAL SERVICES: Your Committee have considered the question of hospitalization generally rather than from the strictly municipal viewpoint. Three main points were discussed, namely:

1. The control of hospitals,
2. Hospital costs,
3. The care of indigents.

An examination of the locations of the hospitals now operating in the Province will show that some areas are over-hospitalized and others are without hospital facilities. The present haphazard method of hospital erection is not desirable as it causes overlapping of service and prevents an orderly systematic development of hospitals, which should be a part of a provincial-wide service.

It appears also that it might be advantageous to classify hospitals and specify the type of service to be rendered.

Increased hospital costs provided the subject of considerable discussion. On behalf of the hospitals the following reasons were submitted for this increase:

(a) The general increase in the cost of living,

(b) More expensively trained and paid nurses who are required to perform services formerly unknown,

(c) A more exact operating room service with better technique, equipment and safeguards,

(d) Improved equipment for treatment including X-Ray, quartz lamps, oxygen machines, etc.,

(e) Increased costs of all drugs and therapeutic remedies,

(f) Extensive use of expensive vaccines, infusions, blood transfusions, etc.,

(g) More elaborate service in attention, feeding, and comfort,

(h) Most important, a more enlightened and critical public demanding refinements of service as to diagnosis and treatment and care, all adding greatly to expense.

Your Committee heard no other representations other than those submitted by the hospitals and from these, it would appear the average per patient day cost for hospitalization in Canada is $3.63; while in the United States it is over $4.00. A prima facie case was established showing local institutions to compare favorably with those of other Provinces and States. The only apparent way of reducing hospital costs is to eliminate many of the present refinements of service, but it does not appear probable that the general public would appreciate such action.

The number of indigents seeking hospitalization is apparently increasing and the burden of hospital costs for such patients is becoming a serious one to the municipality. In view of the type of service rendered the public ward rate appears reasonable considering the quality of the service and the accommodation supplied.

There are some possibilities of improvement in this regard which may be briefly indicated:

(1) For the larger hospital centres better equipped out-patient departments would relieve hospital beds;

(2) Municipalization tends to decrease indigent hospital expenses as the patient can often be treated at home;

(3) An adequate visiting nursing service, enabling patients to be treated at home, would reduce the number of cases now using the hospitals;

(4) Proper provision for the aged and infirm, and for chronic illnesses, in suitable institutions, which could be operated at a lesser per bed cost than a general hospital;

(5) Convalescent Homes where the same factor would apply to those suffering from minor ills or convalescing.

The present Municipal Hospital Act is a satisfactory one, provided it is amended, to have the Province divided into hospital areas, and, to make provision for the appointment of a Provincial Hospital Board, which would have control over the hospitals both as to type of service rendered, and the charges for the same; and, also supervision over the attending medical staff.

(c) HEALTH INSURANCE AND OTHER PRACTICAL METHODS FOR THE MORE EQUAL DISTRIBUTION OF THE COST OF ILLNESS:

Your Committee agrees that because of the many new and costly methods of diagnosis and treatment, that the burden and expense of illness, particularly in cases of prolonged sickness is too heavy and impossible a burden for sick people to bear, and that people should contribute when they are well for the fight against disease.

Much data was supplied in the Departmental Report as to Health Insurance Schemes in vogue in various countries, and we feel, after due consideration, that a scheme of health insurance is not at the present time practicable for the whole of the Province, but might be applied to cities, towns, or other localities where individuals are regularly employed, but the details would have to be worked out on an actuarial basis. It is felt that in the sparsely populated areas the cost and difficulty of collection make it impracticable; but, in cities and towns, health insurance appears to be a logical and fair method of providing for illness in advance; and that it is desirable in such cities and towns to allow, as far as possible, freedom of choice of doctor by patient where more than one doctor is available.

(d) LOGICAL HEALTH AREAS: Your Committee recognizes the need for a logical and sensible division of the Province for health activities to prevent, in future, much needless expense, duplication, and over-lapping of service.

(e) PUBLIC MEDICAL SERVICES:

1. *Mental Disease*: Dr. A. T. Mathers pointed out, in his submission to the Committee, that so far as mental disease is concerned its care has become a State duty throughout the English-speaking world. Mental cases in Manitoba have been increasing at the rate of four (4%) per cent. per year for the last ten years, and the Province is 225 beds short of the necessary requirements at the present time.—the shortage being in a large part reduced by the erection of a new building at Brandon. Mental deficiency is a product of a variety of causes. Defective heredity was formerly thought to be the chief cause, and sterilization was urged as an effective cure, but we are now seized of the fact that it is not the panacea it was hoped to be. A considerable proportion of the cases of mental deficiency are the outcome of accident or disease affecting the child before, during, or after birth. Thus the problem of mental defect becomes closely bound up with prenatal care, better obstetrics, and the prevention of the accidents and diseases of childhood.

The necessity of follow-up work in the case of those discharged from mental hospitals after treatment is one in which the municipal authorities and

other public health services could effectively co-operate. Equally important is the necessity of public health nurses receiving mental hospital training. The problem of the teachers in public schools, who have always to deal with a certain number of defectives, could be made easier if they had a better knowledge of the methods necessary in such cases.

In order that the work in the control of mental disease and mental defectives may be facilitated your Committee make the following suggestions:

1. Public health nurses should be given a measure of training in mental hospitals;
2. Normal school students should be given special instruction in the teaching and training of backward and defective children;
3. The proposed Mental Deficiency Act should be enacted as a part of the statutory law of the Province;
4. Mental hospital treatment should include a follow-up treatment through local agencies, particularly public health nurses;
5. Admission certificates to mental hospitals should be so worded as to avoid the use of invidious terms such as "insane", etc.;
6. Selective sterilization should receive consideration.

(e) 2. *Tuberculosis*: In regard to Tuberculosis, Manitoba stands well in comparison with other Provinces. The people, in general, are well informed about this Disease, and co-operate willingly and intelligently in many anti-tuberculosis measures. The Health Department of the Province, the Public Health Nursing Services, and the Medical men, generally, have been of great assistance to those in charge of the work. Particularly valuable has been the co-operation of the Municipalities of the Province. In 1909 they helped build the Manitoba Sanatorium at Ninette and their arrangement of the levy opened its doors widely to those who needed its care. Travelling clinics began in 1926 as an extension of the work at Ninette and have expanded year by year, supported entirely by the sale of Christmas seals. Largely because of the travelling clinics the bed accommodation of the Sanatorium at Ninette and the King Edward Hospital in Winnipeg became inadequate. In 1930 a Central Tuberculosis Clinic was started in Winnipeg, and in 1931 the large and splendidly equipped St. Boniface Sanatorium was opened.

Any general policy in regard to tuberculosis must be based upon the fact that tuberculosis is an infectious disease and active and infectious cases must be hospitalized and suspects and contacts kept under observation and control. To carry out this general policy:

(1) All agencies, Sanatoria Boards, Travelling Clinics, Public Health Nurses, should co-operate under the auspices of the Sanatoria Board of Manitoba;

(2) Sanatorium and hospital beds should be used economically and carefully, getting the greatest amount of good for moderate expenditure. Public safety should be the first consideration in public expenditure;

(3) Travelling clinics should continue to expand under present auspices and all clinic agencies work in unison.

(f) PRACTICAL METHODS FOR MAKING DIAGNOSIS AND TREATMENT MORE READILY AVAILABLE TO THE PUBLIC GENERALLY:

The evidence submitted to your Committee indicates that in cities and urban areas diagnostic equipment is available that enables even the most

needy patient to have the advantage of diagnosis by medical men aided with modern scientific equipment. But in many areas of the Province such equipment is not available and those suffering from disease may be unable to, owing to lack of means, travel any great distance to secure the benefit of diagnosis of any expert mind. Such facilities would make possible the earlier diagnosis of blood diseases, internal cancer, kidney trouble and many other ailments.

The same fact is equally true in regard to the more advanced and difficult types of surgery. The free clinics of the cities attend to those resident in the City, or, able to reach the City, but in the outlying areas the facilities are not available. We think every citizen of the Province is entitled to the same treatment; that there should be made available for those living in rural Manitoba the modern and effective methods of diagnosis. To this end it has been suggested that at a few strategic points diagnostic clinics should be established that would bring to such areas the advantages now confined and restricted to urban centres. Such clinics could be operated by those in charge of the local hospital, and expense kept to a minimum by having visiting experts at intervals.

Evidence submitted by the Manitoba Dental Association shows that many parts of the Province are without adequate dental service. Exceptionally good work has been done by the clinics operated by the Manitoba Dental Association in portions of Unorganized Territory, but their efforts show the great task that is still unaccomplished. The importance of sound teeth is now so clearly recognized, and the serious effect of diseased teeth on the general health so apparent, that any scheme of public health services will have to recognize the necessity of providing dental services at a price and place, within reach of all.

RECOMMENDATIONS

1. THAT a Commission be appointed, by the Lieutenant-Governor-in-Council, to consider the health needs of the Province as a whole, and to formulate a plan on a sound actuarial basis whereby health services will be available to every resident of the Province at a reasonable cost, which should be provided for in advance and distributed equitably;
2. THAT the Commission consist of three members, one representing the public generally; one, the Medical Profession; and one, the Union of Manitoba Municipalities, with power to secure the necessary actuarial assistance;
3. THAT in the formulation of any plan for provincial health services the feasibility of municipalization in rural areas and health insurance in urban areas be considered; and that as far as possible the right of a district to choose its type of local health service and the right of the individual to choose his physician be recognized.

AND WE FURTHER RECOMMEND THE FOLLOWING CHANGES FOR IMMEDIATE ATTENTION:

4. THAT there be a complete revision of the Public Health Act, and the Regulations passed thereunder, in order to facilitate the work of disease prevention and health preservation, and particularly to provide for more effective enforcement of the Public Health Laws of the Province of Manitoba;
5. THAT the composition of the Provincial Board of Health for the Province of Manitoba be changed so as to include representation from the public generally;

6. THAT amendments be made to the Municipal Act aimed to regulate the appointment of municipal doctors and to provide for uniformity, and to avoid a haphazard development of the scheme;
7. THAT the work of the Dental and Tuberculosis Clinics should be encouraged and their services increased in so far as conditions will permit;
8. THAT the Provincial Board of Health in co-operation with the Department should plan a Division of the Whole Province into logical, or feasible, areas to prevent overlapping and duplication, and aimed to facilitate a more efficient plan of health services.

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COMMUNICABLE DISEASES REPORTED
Urban and Rural : May, 1932

Occurring in the Municipalities of:

Measles: Total 512—North Cypress 179, St. James 114, Kildonan West 33, Swan River R. 22, La Broquerie 21, Rosser 15, Morris T. 12, Minitonas 11, Transcona 6, unorganized 4, Woodlands 3, Ochre River 4, Hillsburg 2, St. Boniface 2, Dauphin T. 1, Lorne 1, Minnedosa 1, Portage City 1, Roblin R. 1, Roblin V. 1, Rockwood 1, St. Vital 1, Winnipeg 76.

Chickenpox: Total 138—Winnipeg 63, Roblin R. 21, Lawrence 13, Cameron 11, Pipestone 5, Silver Creek 4, Strathclair 3, Birtle 3, La Broquerie 3, St. Boniface 2, unorganized 2, Archie 1, Argyle 1, Fort Garry 1, Hamiota 1, Lorne 1, Minto 1, Ochre River 1, Sifton 1.

Whooping Cough: Total 102—North Cypress 34, Winnipeg 32, Minitonas 17, Brandon 11, St. Boniface 5, Swan River R. 2, St. Vital 1.

Cancer: Total 81—Rural Manitoba 51, Winnipeg 30.

Mumps: Total 80—Winnipeg 31, Russell T. 26, Transcona 9, Archie 6, Rockwood 4, Silver Creek 2, Bifrost 1, Pipestone 1.

Scarlet Fever: Total 68—Winnipeg 41, St. James 5, Lac du Bonnet 3, St. Boniface 3, unorganized 3, Bifrost 2, Birtle T. 1, Birtle R. 1, Brooklands 1, Franklin 1, Kildonan W. 1, La Broquerie 1, Morton 1, Rhineland 1, Rosedale 1, Selkirk 1, St. Clements, 1.

Trachoma: Total 41—Rhineland 25, Gretna 5, Portage R. 5, Morden T. 3, Roblin R. 2, Stanley 1.

Tuberculosis: Total 38—Winnipeg 11, Pipestone 2, Selkirk 2, St. Andrews 2, Argyle 1, Carberry 1, Carman 1, Chatfield 1, Coldwell 1, Dauphin R. 1, Edward 1, Fort Garry 1, Gimli V. 1, Morden T. 1, Morton 1, Pembina 1, Roblin R. 1, Shoal Lake R. 1, Stanley 1, Swan River T. 1, St. Boniface 1, St. Laurent 1, St. Vital 1, Westbourne 1, Woodlands 1.

German Measles: Total 33—Hamiota R. 8, Ericksdale 7, Brandon 6, Louise 4, Portage R. 3, St. Boniface 2, Kildonan W. 1, Roblin R. 1, Tuxedo 1.

Diphtheria: Total 28—Winnipeg 20, Ethelbert 2, unorganized 2, Dauphin R. 1, Portage C. 1, Springfield 1, Winnipegosis 1.

Typhoid Fever: Total 7—Cartier 3, Brandon 1, Eriksdale 1, Lansdowne 1, Winnipeg 1.

Erysipelas: Total 4—Winnipeg 2, Stonewall 1, St. Clements 1.

Influenza: Total 3—Winnipeg 2, Brandon 1.

Cerebrospinal Meningitis: Total 1.—Unorganized 1.

Diphtheria Carrier: Total 1—Unorganized 1.

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DEATHS FROM ALL CAUSES IN MANITOBA
For Month of April, 1932

URBAN

Cancer 28, Congenital 17, Pneumonia (all forms) 14, Tuberculosis 11, Influenza 4, Puerperal 2, Erysipelas 2, Scarlet Fever 1, Typhoid Fever 1, Whooping Cough 1, Lethargic Encephalitis 1, all other causes 154. Total 236. Stillbirths 14.

RURAL

Tuberculosis 23, Congenital 34, Cancer 20, Pneumonia 17, Influenza 13, Scarlet Fever 4, Cerebrospinal Meningitis 3, Measles 2, Erysipelas 2, Diphtheria 1, Poliomyelitis 1, Puerperal 1, all other causes 136. Total 257. Stillbirths 19.

INDIANS

Tuberculosis 8, Pneumonia 4, Congenital 4, Diphtheria 1, Influenza 1, Puerperal 1, all other causes 2. Total 21. Stillbirths 1.

Manitoba Medical Association

Minutes of a meeting of the Winnipeg members of the Executive of the Manitoba Medical Association, held in the Club-Rooms of the Medical Arts Building on Friday, June 10th, 1932, at 12.30 noon.

Present:—

Dr. Ross Mitchell
Dr. F. G. McGuinness
Dr. F. A. Benner
Dr. A. G. Meindl
Dr. R. R. Swan
Dr. Noel R. Rawson
Dr. W. H. Secord
Dr. W. G. Campbell
Dr. G. S. Fahrni
Dr. J. S. McInnes
Dr. F. W. Jackson

Committees for Annual Meeting.

The following were appointed Conveners of the various committees for the Annual Meeting of the Association:—

Hotel, Reception and Auto	Dr. J. S. McInnes
Finance	Dr. F. G. McGuinness
Press and Publicity	Dr. J. M. McEachern
Scientific Exhibits	Dr. Digby Wheeler
Commercial Exhibits	Dr. E. H. Alexander
Entertainment, Dinners and Luncheons	Dr. R. R. Swan
Ladies' Committee	Mrs. Ross Mitchell
Registration and Tickets	Dr. F. W. Jackson
Resolutions	Dr. G. S. Fahrni
Programme	Dr. Ross Mitchell Dr. F. W. Jackson

Contraception.

The committee on contraception appointed by the President made an interim report, outlining resolution which they think will be the outcome of their deliberations. The matter was to be further considered and a meeting held with a like committee from the Winnipeg Medical Society, as advised in their letter of June 7th.

Cancer Relief & Research Institute.

Letter from the above under date of June 6th was read, requesting the Association to appoint representatives to their Board of Trustees for the coming year.

It was moved by Dr. F. A. Benner, seconded by Dr. J. S. McInnes: That Dr. Hugh MacKay, whose term expired May 31st, 1932, be re-appointed as a representative of this Association for three years. —Carried.

Representatives to C.M.A. Council.

Owing to the illness of Dr. Adamson, it was found necessary to appoint an alternate to the Executive Committee of the C.M.A. It was agreed that Dr. Fahrni take Dr. Adamson's place as representing Manitoba, and the Secretary was instructed to write Dr. Routley to this effect, also advising that the following were our representatives to the C.M.A. Council for the Annual Meeting in June:—

Dr. G. S. Fahrni
Dr. J. D. McQueen
Dr. A. W. S. Hogg
Dr. O. S. Waugh
Dr. D. A. Stewart
Dr. C. W. Burns

Correspondence.

Letter from the Winnipeg Medical Society, under date of June 7th, was

read, advising that Dr. R. R. Swan had been appointed as their representative to the Executive of the M.M.A. for the coming year.

Letter from The Farmer's Wife, Saint Paul, Minn., under date of June 6th, re. contract practice was read, and the Secretary was instructed to reply to same.

Letter from the C. P. & S. under date of May 26th was read, requesting that the Association set apart space for an open meeting of the College when arranging the programme for the Annual Meeting in September.

It was moved by Dr. F. G. McGuinness, seconded by Dr. F. A. Benner: That this letter be turned over to the programme committee for their attention. —Carried.

The meeting then adjourned.

A PLEA FOR DOCTORS

Some of my doctor friends tell me that during these dark days they aren't as busy as they used to be. People cannot afford to be sick; withering of the bank roll has denied them the joy of ill-health, and those who do become ill get up out of their sick beds promptly and start hustling a living. Surgeons are just as busy as they ever were, but neither internal medicine men nor surgeons are making the money they used to make and aren't collecting very much of what they earn.

It is a rare thing for a doctor to sue one for his bill, for to a very great extent physicians are a soft-hearted, sympathetic lot, and if a patient cannot pay his bill they never bother him very much about it, or else make their fee so reasonable that none but those lost to a sense of shame will evade payment of it.

Once I heard a very rich man scream in agony because a noted surgeon had charged him a thousand dollars for removing his appendix. Now this man knew he could afford the best, and he wanted the best and got it. He would have been afraid to entrust his fat person to a doctor who would have done, perhaps a job equally good for a hundred dollars.

Yes, he wanted the best, but after he had had the best he graded it with the mediocre—as far as remuneration was concerned.

He submitted to that operation feeling perfectly secure and serene because he knew he was in unusually skillful hands, and he forgot such skill and such a reputation for skill had not been acquired save by long years of apprenticeship, during which thousands of appendixes had been removed without charge.

He forgot that his life was worth more to the community than that of a charity patient, and he refused to pay the bill without indulging in a disgusting tirade and pleading poverty and oppression.

People forget that the doctor, like the concert singer, may not adhere to one price; that the rich patient must bear the responsibilities of the rich and the strong to society's general health by taking up the slack of the doctor's support where the poor and weak fail.

The true physician has in him a Christlike quality. He has a vast sympathy for sick people, a vast pity for the poor and the helpless. So he is imposed upon, for most human beings are alert to note quick and unstinted sympathy, and are not at all averse to trading upon it.

And the doctor, who knows human beings so much better than they know themselves, is, somehow, neither shocked, distressed nor made bitter by evidence of ingratitude.

Few persons realize how hard earned is the doctor's competence, which, nine times out of ten, is surprisingly modest. He is the last relic of civilized slavery.

He goes to the theatre, telling himself he shouldn't, because Old Lady Gazookis is in the hospital and she's just the sort to whom a minor gas pain will mean a capital operation.

So the doctor leaves his seat number and name at the box office, and in the middle of the second act an usher comes and whispers that the doctor is wanted on the telephone. And it's Old Lady Gazookis!

If a doctor is the proprietor of a half decent practice he seldom eats a meal in peace, and in his middle years, what with hastily eaten meals and broken rest and overwork, he surrenders to angina pectoris, the scourge of the medical profession, and a youthful hopeful steps into his practice and goes the same route in the fullness of time.

* * *

Doctors and army and navy officers have in them something of the same holy zeal of a monk. Their professions call for a renunciation of worldly wealth and place; they work for the joy of the job and get little thanks and much criticism for it, and are never really appreciated until a grave emergency arises.

I am much in favor of doctors. The only one I never liked was an army medico who got a private by the name of Kyne mixed up with another private by the name of Klein, and slipped Kyne three large breakers of epsom salts intended for Klein. At that the poor doctor was terribly sorry, and I suppose Kyne would have forgiven him if he hadn't been suffering from tropical dysentery at the time.

Some sentimentalist (I suspect he was a florist) invented Mother's Day. I believe we ought to have Doctor's Day, and on that day send in our cheques for all we owe our doctor in cash and try to express something of what we owe him for the things that money can never buy.—*Peter B. Kyne in Chicago Herald and Examiner.*

Medicine is a progressive science and knows not the meaning of stagnation. We must either advance or retreat. Hindering and hampering obstacles in the paths of advancement can result in but one thing—retreat, with its detrimental effect on the health of mankind.—*C. W. Waggoner.*

CLINICAL MEETINGS

At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during college term.

Winnipeg Medical Society—
3rd Friday, Medical College, at 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Building.

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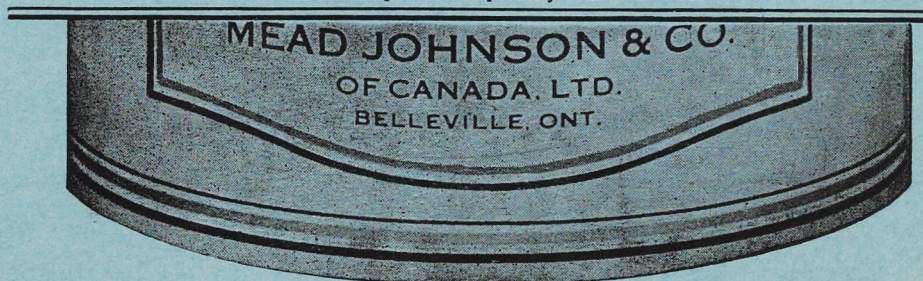

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